APPENDIXES

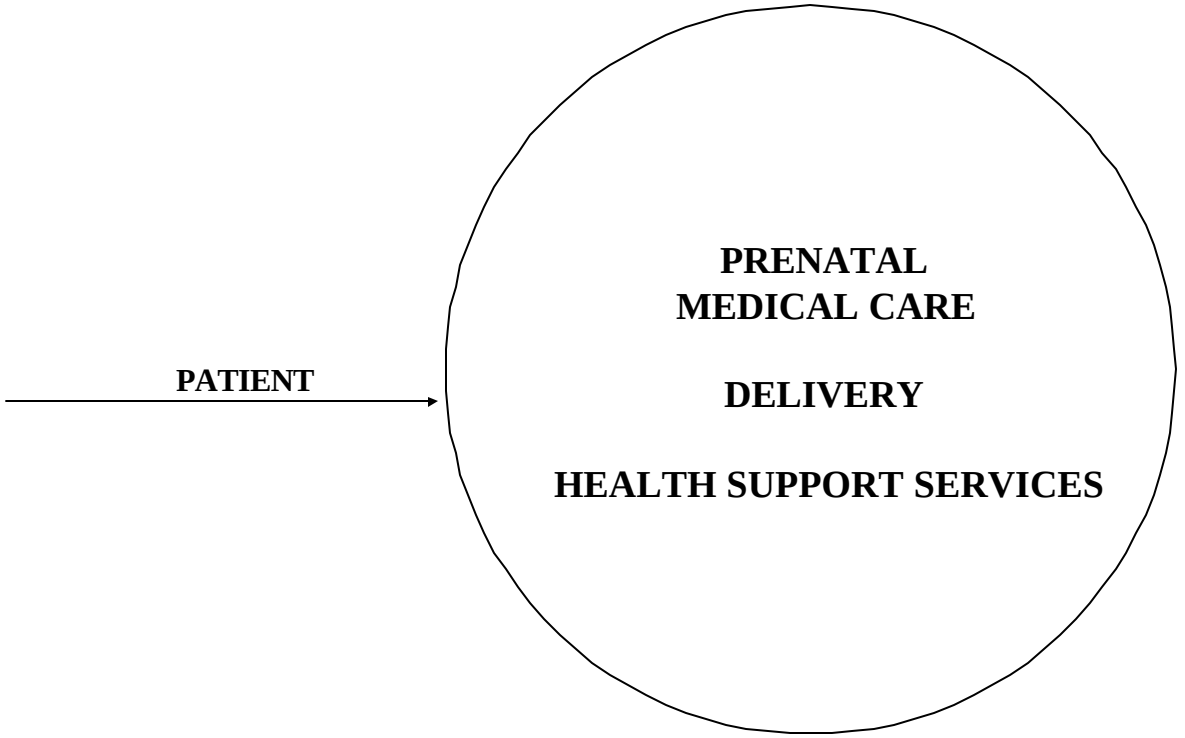
APPENDIX

1. Comprehensive Organizational Structure Models.
2. Obstetrical Services Risk Assessment Tool Sample.
3. Plan of Care Sample Tool.
4. Health Education Curriculum Guide Sample.
5. Health Education Instruction Check List Sample Tool.
6. Case Coordinator Activities.
7. Health Education Services.
8. Nutrition Services.
9. Social Psychological Services.
10. Patient Rights Responsibilities.
11. Postpartum Health Support Service/Preventive Health Care Contact Tool.
12. Release Of Information Consent Form Sample.
13. New Jersey Department of Health and Senior Services HIV “REQUIRED” Consent Form.
14. Presumptive Eligibility (PE) FD 334 revised 5/94.
15. WIC HealthStart Forms Number H4383 “HS-8 3/95”.
16. Weight Chart Form Number H4388 “HS-7 4/95”.
17. Recertification Forms (3 Pages “HS-12”, 1 Page “HS-9”).
18. Health Support Reimbursement Rates.
19. Obstetrical Care Reimbursement Rates.

APPENDIX 1

MODEL 1: COMPREHENSIVE MATERNITY CARE - ONE PROVIDER

SINGLE SITE MODEL

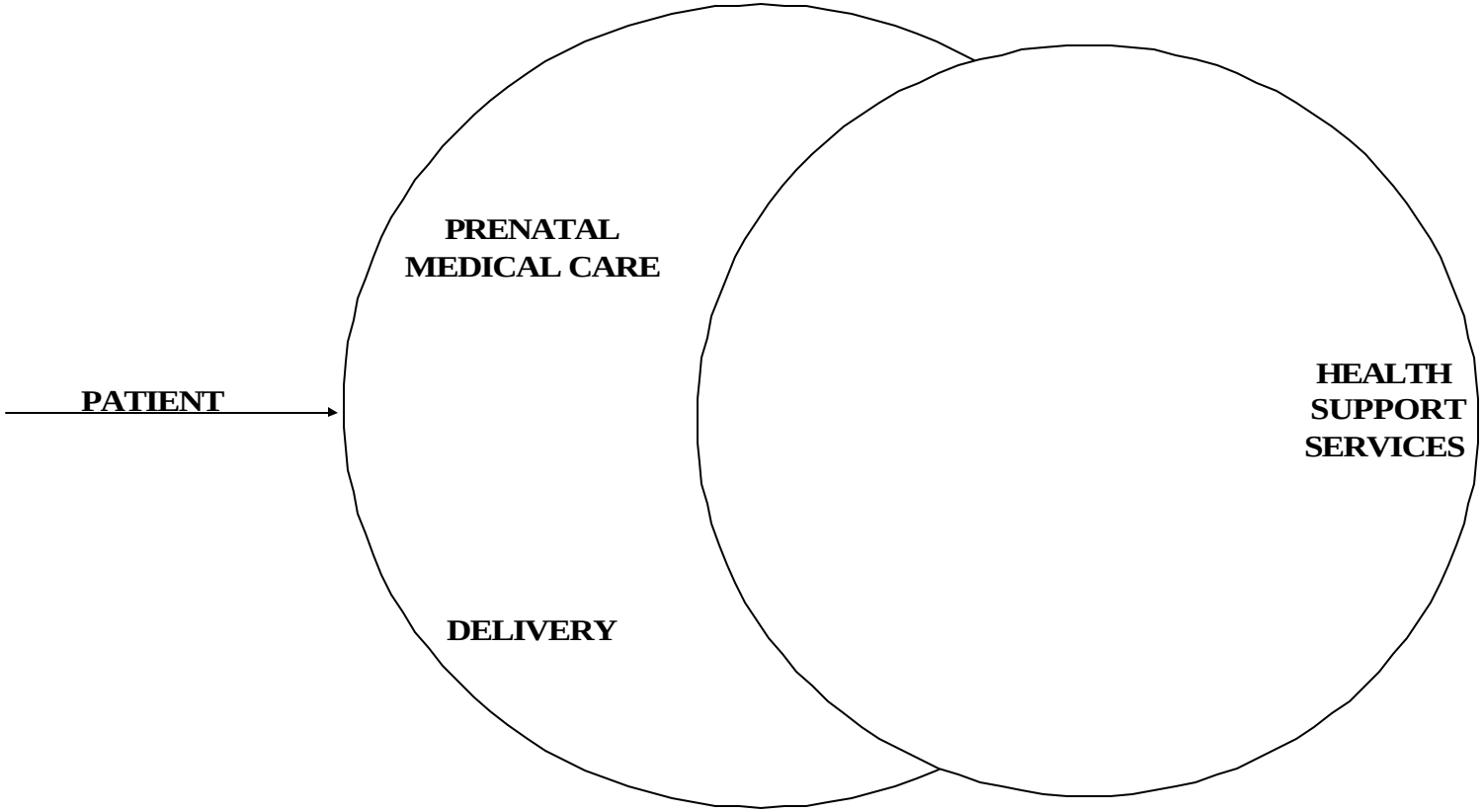


One provider provides the medical and health support services. This is the basic Model involving one provider who delivers the entire maternity care services package. This provider can be agency based or private practiced-based.

APPENDIX 1A

MODEL 2: TWO (2) PROVIDERS AGREES TO JOINTLY PROVIDE COMPREHENSIVE MATERNITY CARE SERVICES

LINKAGE MODEL

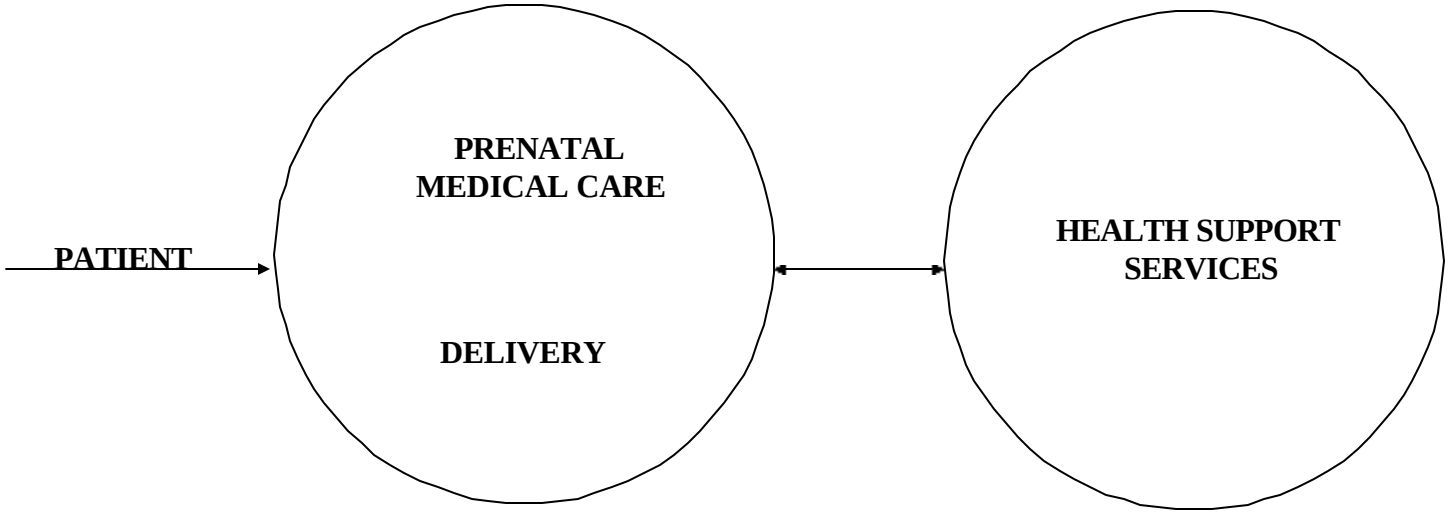


One provider agrees to provide the medical component and the other provides the health support services component. For example, a private practice (physician, certified nurse midwife, nurse practitioner or a group of practitioners) may provide the medical component at one site accessible to the patient population, and the health support services may be provided at another site such as a hospital outpatient clinic, local health department, community health center, health maintenance organization.

APPENDIX 1B

MODEL 3: ONE PROVIDER WITH AGREEMENT FOR REFERRAL

REFERRAL MODEL

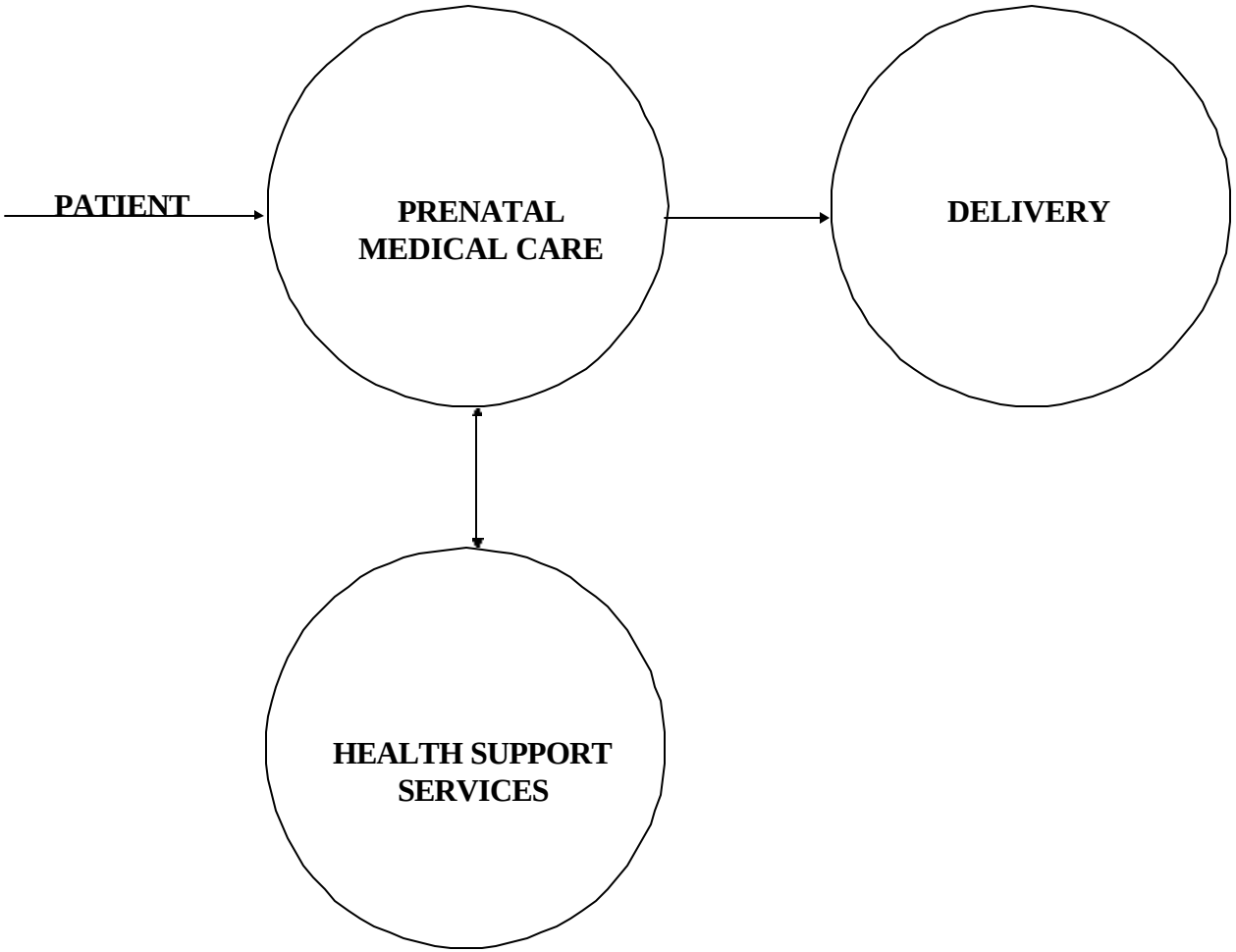


A provider refers to another provider for provision of either the medical component or the health support services component. All providers must be recognized and approved Medicaid providers in New Jersey.

APPENDIX 1C

MODEL 4: ONE PROVIDER WITH MULTIPLE REFERRAL AGREEMENTS

MULTIPLE REFERRAL MODEL

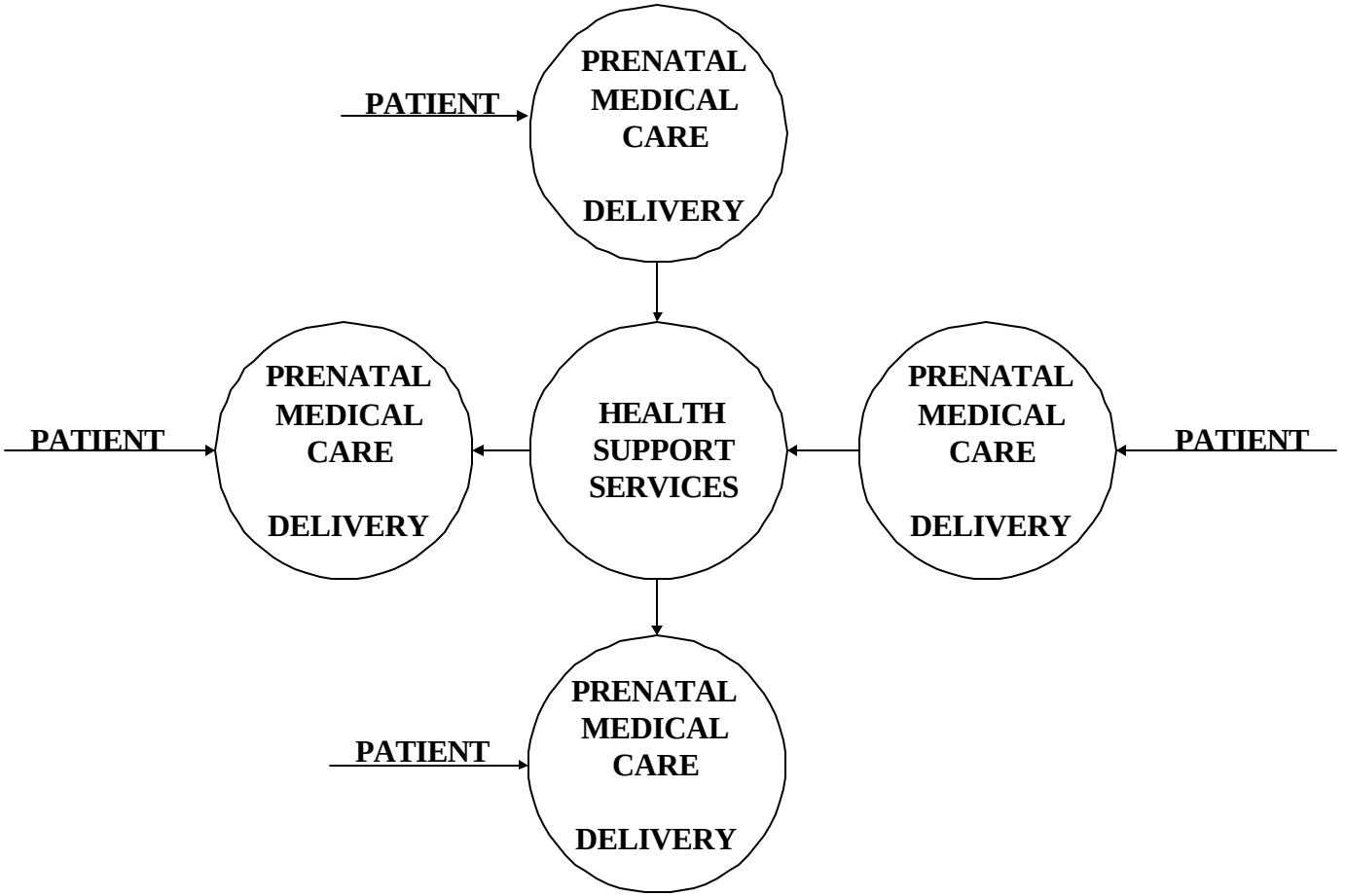


This is a combination of Models 1, 2, 3 and hospital of delivery services and health support services. The difference is that the medical care provider for prenatal care services is entirely different than one providing the delivery service. For example, a family practice physician may provide prenatal care and refer for health support services. The obstetrical care provider for the delivery may be a physician (house resident covering, an attending, and/or on-call physician) or a certified nurse midwife of the hospital generally, but not necessarily, used for delivery.

APPENDIX 1D

MODEL 5: CORE REFERRAL PROVIDER

MULTIPLE PROVIDER REFERRAL MODEL



Providers of both prenatal medical care and delivery services refer to one specific provider for health support services.

APPENDIX 2

OBSTETRICAL SERVICES						
Age	**OB/Index**	**Gravida**	**Term**	**Premi**	**Ab-ECT**	**Living**
LMP	**EDC**		**Corrected EDC**			

RISK ASSESSMENT

Patient May Be At Increased Risk For

9 Early Pregnancy Loss	9 PIH/Preeclampsia
9 Fetal Genetic Abn	9 Post-term Pregnancy
9 Fetal Structural Abn	9 Medical Complications
9 Gestational Diabetes	9 Surgical Complications
9 Maternal/Fetal Infection	9 Management Plan Conflict
9 Isoimmunization	9 Emotional Difficulty
9 Size-Date Discrepancy	9 Labor/Delivery Difficulty
9 IUGR	9 Parenting Difficulty
9 Preterm Labor/Delivery	9 OTHER

9 **PATIENT NOT AT INCREASE RISK AT INITIAL ASSESSMENT**

Signature-Date

RISK ASSESSMENT UPDATES (as indicated)

Date	GA	Signature	Date	GA	Signature

SAMPLE **SAMPLE** **SAMPLE**

PLAN OF CARE

CASE COORDINATOR: Mary A. Lawrence, RN
10/21/93

PATIENT: Mary A. Lawrence - EDC 1/12/95

Problem	Goal	Intervention/Responsible Person	Outcome
10/20/93 Poor Weight Gain	Increase weight to ____ lbs. by 6 months of pregnancy	Provide Specialized Nut Ed. M.L. RD Monitor Med. Report. J.V. MD see Nut. notes of 10/20/93	10/22/93 enrolled in WIC program 10/22/93 kept Nut. appointment 12/10/93 what was approp. for gest. age and ht.
10/20/93 Substance Abuse	Refrain from chemical use during this pregnancy	Education re: substance use (see HE and SW counseling noted) Blood and urine test ordered	Attends counseling sessions as planned, follow maintenance program as planned Blood/urine completed 10/15/93 Refer to CAC
No Problem this trimester (Date)			

***This is a sample Plan of Care**

APPENDIX 4

Health Education Curriculum *(all topics listed should be covered with modifications depending on the timing of the patient's entry into prenatal care.)*

First Trimester

Normal physical and emotional changes during pregnancy

Fetal growth and development

Normal discomforts during pregnancy, such as nausea, breast changes, frequent urination, tiredness

Examples of warning signs, such as vaginal bleeding heavy discharge painful urination, frequent headaches, blurred vision, signs and symptoms of preterm labor

Personal hygiene care including perineal care

Level of activity, such as continuing work and/or education, sexual activity, exercise, and rest

Lifestyle habits, including car safety and avoidance of alcohol, caffeine, tobacco, illegal drugs, and self-prescribed medications

Possible occupational and environmental hazards, such as toxoplasmosis, rubella, x-ray, chemicals

Need for continuing medical and dental care: for minor illnesses and for pre-existing major illnesses, such as diabetes, hypertension

Second Trimester

Readiness for childbirth preparation: including the concept of prepared childbirth, birth partners, identifying tension/stress, exercises for relaxation

Normal physical and emotional changes during pregnancy

Fetal growth and development

Normal discomforts of pregnancy, such as disrupted sleep patterns, weight gain/loss, muscle cramps, constipation, heartburn, lower abdominal pain

Examples of warning signs, such as: vaginal bleeding, heavy discharge, painful urination, frequent headaches, blurred vision, signs and symptoms of preterm labor, absence of fetal activity

Personal hygiene care including perineal care

Level of activity, including continuing work and/or school, sexual activity, exercise and rest

Lifestyle habits, including car safety and avoidance of alcohol, caffeine, tobacco, illegal drugs, self-prescribed medications

Possible occupational and environmental hazards, such as toxoplasmosis, rubella, x-ray, chemicals

Need for continuing medical and dental care

Third Trimester

Child birth education course including:

- Labor process, including signs of onset of labor (2-4 weeks before, 2-3 days before, 3 cardinal signs), vaginal delivery and cesarean section
- Management of labor, including prepared childbirth methods, medications, and different types of anesthesia/analgesia during delivery
- Visit to hospital where delivery is to be performed

Preparation for hospital admission, including care for older children during hospital stay, hospital routine, what to take to the hospital, and planning for the trip home

Newborn needs and development, including infant crying, sleeping patterns, eating patterns, pediatric care, circumcision, routine newborn screening tests

Preparations for the basic care of the infant including bathing, layette, car seat

Preparation of the family/household for the infant

Continuing medical care, including the importance of the postpartum visit
Future family planning service needs

Normal physical and emotional changes during pregnancy

Fetal growth and development

Normal discomforts during pregnancy, such as disrupted sleep patterns, weight gain, muscle cramps, constipation, heartburn, lower abdominal or back pain, tiredness

Examples of warning signs such as signs and symptoms of preterm labor, frequent headaches, blurred vision, painful urination, heavy discharge, absence of fetal activity

Level of activity, such as continuing work and/or education, sexual activity, exercise, and rest

Lifestyle habits, including car safety and avoidance of alcohol, caffeine, tobacco, illegal drugs and self-prescribed medications

Postpartum

Review of labor and delivery

Normal physical and emotional changes after the birth, including adjustments to the role of mother, postpartum depression, physical changes of the puerperium, and resumption of menstrual cycle

APPENDIX 4

Normal discomforts of the mother after the birth

Level of activity after giving birth, including postpartum sexual activity

Lifestyle habits, including avoidance of alcohol, caffeine, tobacco, illegal drugs, and self-prescribed medication

Future family planning information and services

Infant growth and development during the first three months of life

Basic care of the infant including feeding, bathing/diapering, safety, sleeping

Adjustment of the family/household to the new infant

Examples of warning signs for mother and infant which need medical attention

Need for continuing medical care for mother and infant including pediatric care, care of circumcision, prescribed medications

APPENDIX 5

SAMPLE **SAMPLE** **SAMPLE**

HEALTH EDUCATION NEEDS AND INSTRUCTION CHECKLIST					
Subjects	**Immediate or Strong Interest**	**First Trimester**	**Second Trimester**	**Third Trimester**	**Postpartum**
	(Check line below if patient emphasized during initial assessment)	(Enter date below when instruction is completed)			
Normal physical and emotional changes during pregnancy/after birth	_____	9	9	9	9
Fetal/infant growth and development	_____	9	9	9	9
Normal discomfort during pregnancy/after birth	_____	9	9	9	9
Personal hygiene	_____	9	9		
Level of activity (Sex, exercise, work)	_____	9	9	9	9
Lifestyle habits (smoking, drugs, alcohol)	_____	9	9	9	9
Occupational/environmental hazards	_____	9	9		
Need for continuing medical/dental care for mother and baby	_____	9	9		
Childbirth preparation	_____		9		9
Childbirth education course	_____				9

SAMPLE **SAMPLE** **SAMPLE**

HEALTH EDUCATION NEEDS AND INSTRUCTION CHECKLIST (Continued)

Subjects	Immediate or Strong Interest	First Trimester	Second Trimester	Third Trimester	Postpartum
	(Check line below if patient emphasized during initial assessment)	(Enter date below when instruction is completed)			
Preparation for Hospital Admission	_____			9	
Newborn Needs and Development	_____			9	
Preparation for Basic Care of Infant	_____			9	
Preparation of Family/Household for Infant	_____			9	
Importance of Postpartum Visit	_____			9	
Future Family Planning	_____			9	9
Review of Labor and Delivery	_____				9
Basic Care of Infant	_____				
Adjustment of Family/Household to Infant	_____			9	

Comments/Questions:

_____

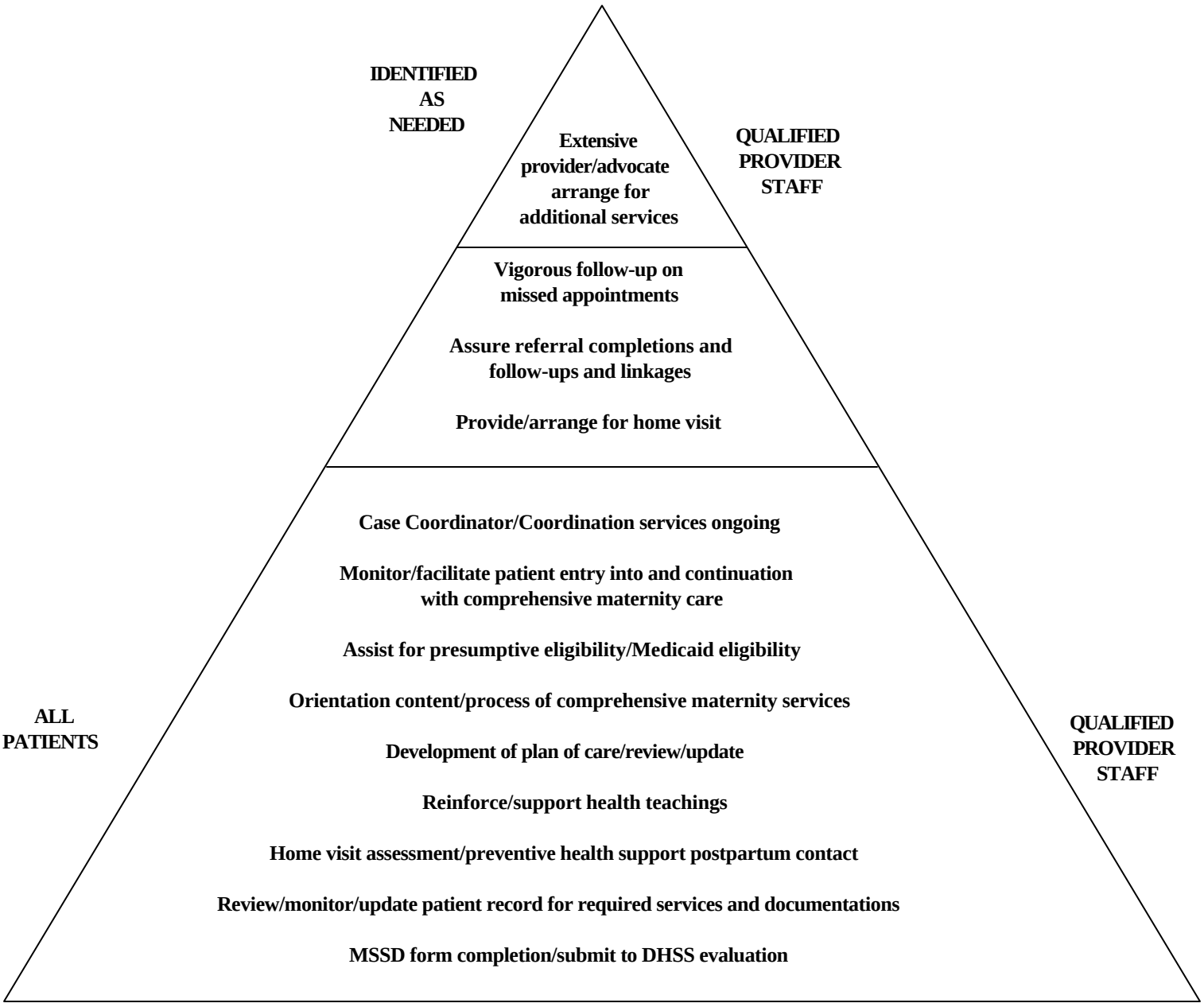
_____

_____

_____

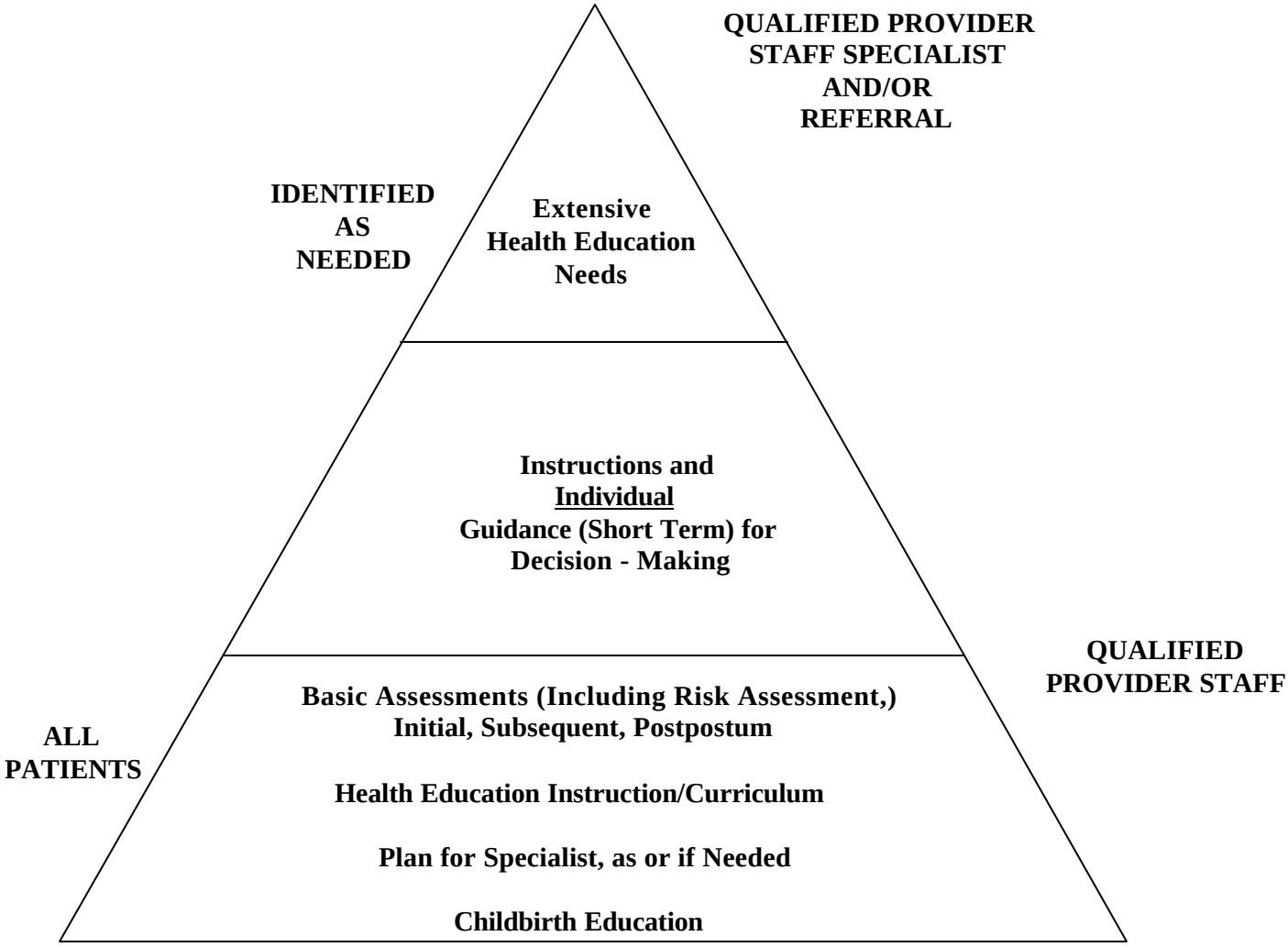
APPENDIX 6

CASE COORDINATION SERVICES



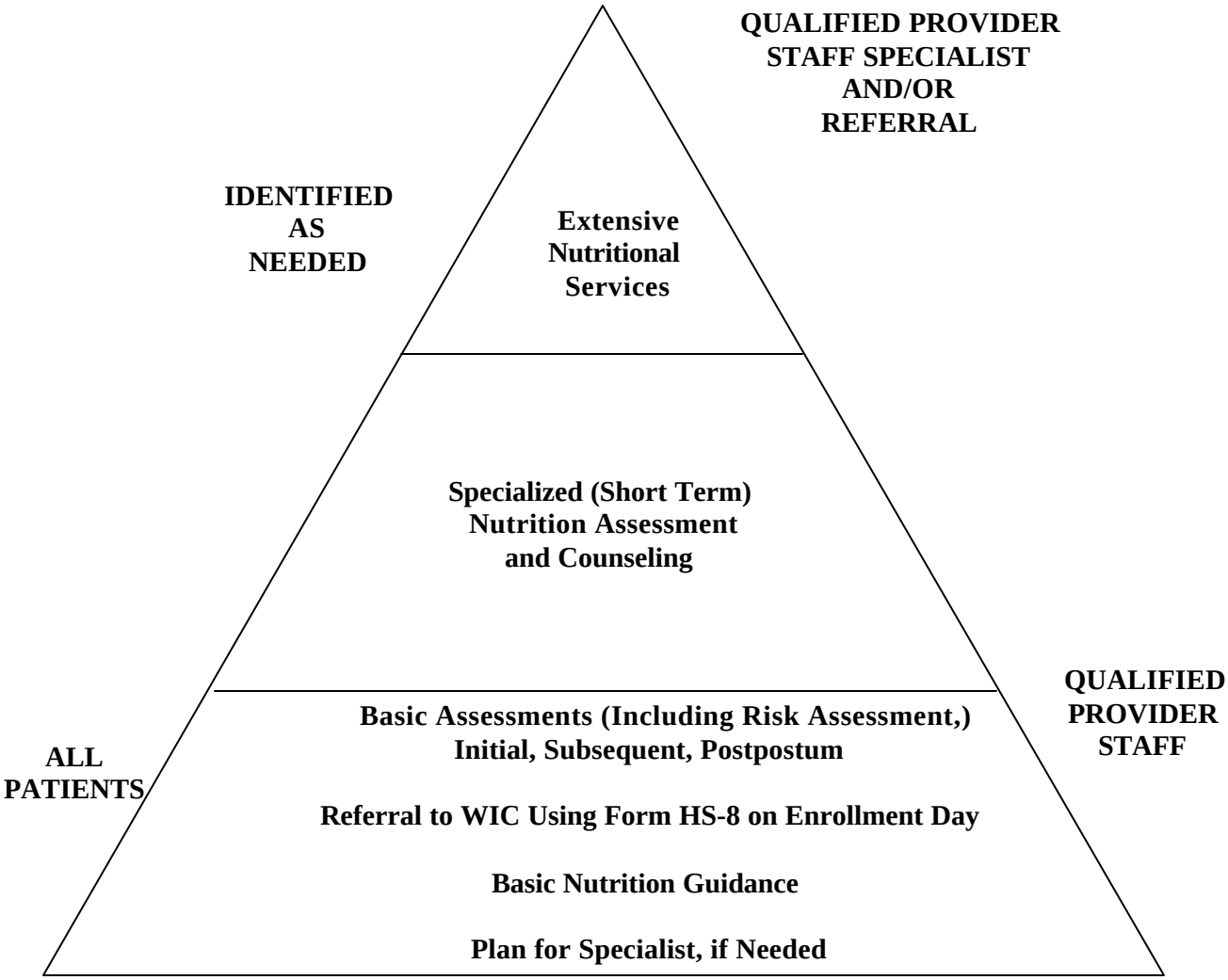
APPENDIX 7

HEALTH EDUCATION SERVICES



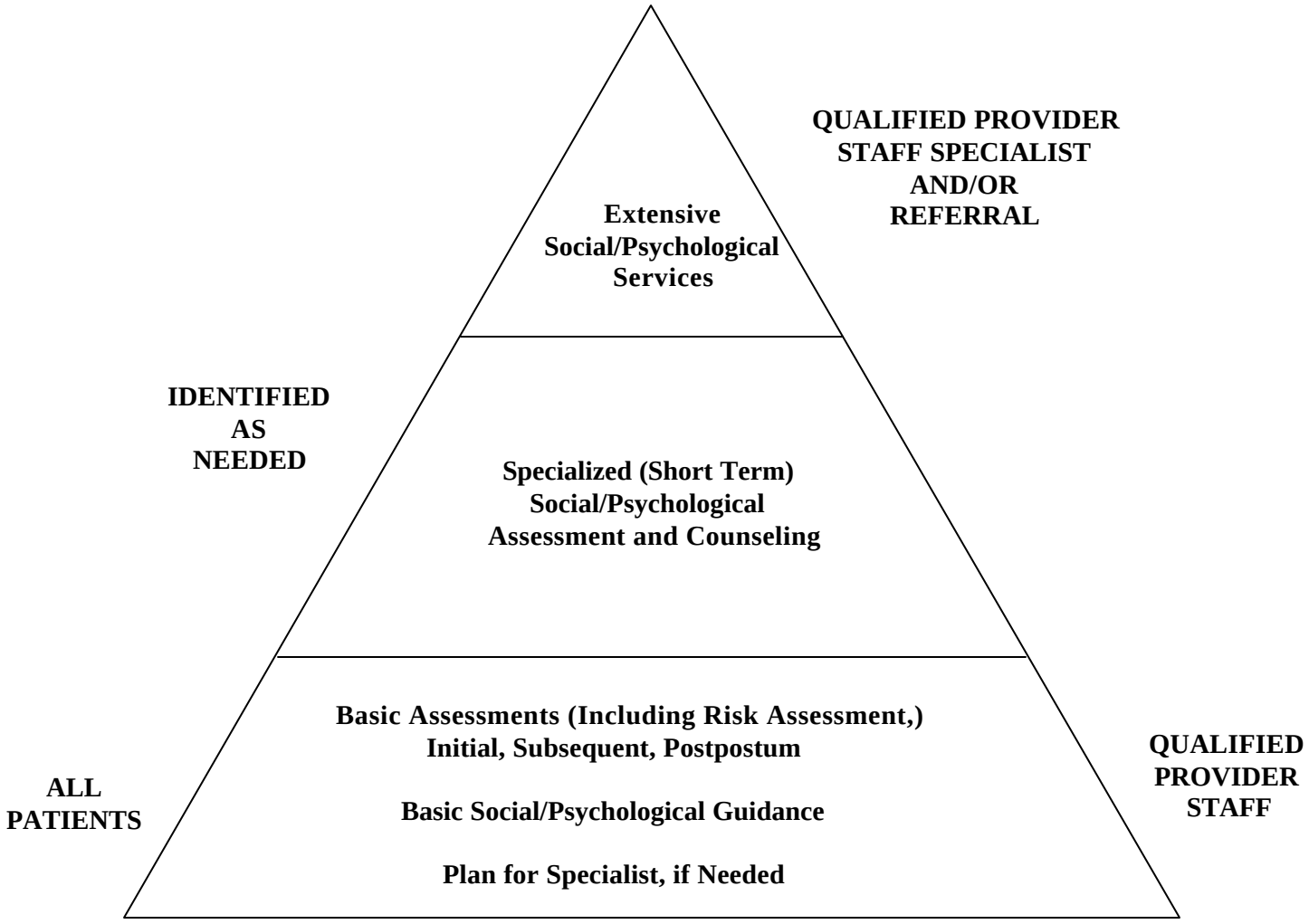
APPENDIX 8

NUTRITION SERVICES



APPENDIX 9

SOCIAL PSYCHOLOGICAL SERVICES



APPENDIX 10

SAMPLE **SAMPLE**

MATERNITY CARE PATIENTS RIGHTS AND RESPONSIBILITIES[1]

Rights:

- To be treated with dignity and respect.
- To maintain your privacy and confidentiality.
- To receive explanations about any tests or clinical procedures and answers to any questions you have.
- To receive education and counseling.
- To review the medical record with the medical care professional providing treatment.
- To consent or refuse any care or treatment.
- To participate in making any plans and decisions about your care during pregnancy, labor and delivery and the postpartum period.

Responsibilities:

- To be honest about your medical history and lifestyle which may affect you or your unborn baby's health.
- To ask questions whenever you do not understand.
- To follow health advice and instructions.
- To keep appointments and complete referrals.
- To report any changes in your health.

[1]The Comprehensive Perinatal Services Program, California Department of Health Services, March, 1987

APPENDIX 11

SAMPLE

AGENCY_____

POSTPARTUM HEALTH SUPPORT SERVICES/PREVENTIVE HEALTH CARE CONTACT

Date _____
Patient=s Name _____ Problems in Hospital _____
Baby=s Name _____ Problems in Hospital _____
Birth Date _____ Birth Weight _____
Discharge Date _____ Discharge Weight _____
Length _____ Head Circumference_____
Gestation _____ Apgar Score _____

How does your baby feed? Breast " Bottle "
How often? _____ Any problems? _____
_____
How does your baby soothe or clam itself? _____
How has your baby changed since birth? _____
_____
Does your baby sleep a lot? _____
Who is your baby=s health care provider? _____
When is (or was) the first appointment? _____
Were there any problems? _____
_____
Do you have any special questions/concerns about yourself, your baby, father of baby, siblings, or other household members? _____
_____
_____
Mother=s Goals/Needs (i.e. finance, emotional, food, housing, clothing, etc.)_____
_____
_____
Referral for identified needs, as appropriate. _____
_____
_____
Plan of Care _____ Completed _____ Reviewed _____
_____
_____
Nurse Signature/Case Coordinator _____ Date _____
Social Worker _____ Date _____
Other _____ Date _____
Health Education/See Health Education Checksheet
Signature _____ Date _____
Nutrition/See HealthStart/WIC Form
Signature _____ Date _____

6 Week Doctor Appointment Date _____ Yes " No "
Family Planning Appointment Date _____ Yes " No "
WIC Appointment Date _____ Yes " No "

APPENDIX 12

New Jersey State Department of Health and Senior Services
HealthStart Program

RELEASE OF INFORMATION

I authorize _____ (agency name) _____ to release any medical and other information about me to the State Department of Health and Senior Services which is needed for the HealthStart program for evaluation under Statute P11987 c.115, and NJAC 10:54 requiring the Department of Health and Senior Services to collect these data to perform the evaluation of the HealthStart program.

I know that the disclosure of my Social Security Number is voluntary and will be kept in strict confidentiality. It will be used only for purposes of evaluation and research by the Department.

Signed _____ Date _____

APPENDIX 13

New Jersey Department of Health and Senior Services

Name: _____

In accordance with Chapter 174, P.L. 1995:

I acknowledge that _____ has counseled and provided me with:
(Name of physician or other provider)

A. Information concerning how HIV is transmitted,

B. The benefits of voluntary testing,

C. The benefits of knowing if I have HIV virus or not,

D. The treatments which are available to me and my unborn child should I test positive, and

E. That I have a right to refuse the test and I will not be denied treatment.

I have consented to be tested for infection with HIV. “

I have decided not to be tested for infection with HIV. “

This record shall be retained as a permanent part of the patient’s medical record.

_____ _____
Date Signature

_____
Witness

C

DMAHS USE ONLY		PROVIDER USE ONLY

State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services

APPENDIX 14

CERTIFICATION OF PRESUMPTIVE ELIGIBILITY

CLIENT INFORMATION:

NAME:_____ **COUNTY OF RESIDENCE:**_____
First MI Last

ADDRESS:_____ **DATE OF BIRTH:** _____/_____/_____

_____ **SOCIAL SECURITY NO.:** _____-_____-_____

TELEPHONE NO.: ( )_____ **HOUSEHOLD UNIT:** _____ **No. of persons in household. If patient is a minor, the household unit is two (the minor & unborn child). Complete and attach deeming worksheet .**

(Check appropriate boxes below:)

Marital Status: [ ] Single [ ] Married [ ] Separated [ ] Divorced [ ] Widowed

Race: [ ] White [ ] Black [ ] Native American [ ] Asian [ ] Hispanic [ ] Other

Citizenship Status: US Citizen [ ] Yes [ ] No Qualified Alien [ ] Yes [ ] No Date of Entry into US: ___/___/___

Does client have pending TANF, NJC or SSI, Medicaid Application? [ ] Yes [ ] No ***(If yes, circle program)***

Medicare Coverage: [ ] Yes [ ] No If yes, HIC Number:_____

Other Insurance Company:_____ Other Insurance Policy No.:_____

INCOME INFORMATION:

Total Household Income:	**Income**	**Frequency**	**Gross Monthly Amt.**	**Source**
Gross Earnings				
Gross Earnings				
Gross Unearned Amount				
Gross Unearned Amount				
Gross Unearned Amount				
Gross Child Support Amount				
Gross Alimony Amount				

TOTAL MONTHLY GROSS INCOME $_____

Child Care Expense Amount:_____ Weekly_____ Biweekly_____ Monthly

PREGNANCY INFORMATION:

Date of L.M.P.:_____ Pregnancy Due Date:_____

CERTIFICATION STATEMENT:

*I,*_____*attest that I have read and agree to the above statements and fully realize that the county welfare agency relies upon the truth and accuracy of my statements. I have received a copy of and understand the Patient Guidelines.*

_____ _____
Applicant Signature *Date*

I certify the above applicant is pregnant and presumptively eligible for limited Medicaid benefits in accordance with N.J.A.C. 10:72-6.1 et seq.

_____	_____	_____
Provider Agency Name	*Address*	*Telephone No.*
_____	_____	_____
Provider Signature	*Date*	*Three-Digit Provider No.*

IMPORTANT: THE ORIGINAL FORM MUST BE FORWARDED TO THE DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES, PRESUMPTIVE ELIGIBILITY UNIT, P.O. BOX 712, MAIL CODE 38, TRENTON, NEW JERSEY 08625-0712, WITHIN TWO (2) WORKING DAYS OF COMPLETION.

WHITE - DMAHS CANARY - COUNTY WELFARE AGENCY PINK - PROVIDER GOLDENROD - CLIENT

FD 334 (Rev. 10/98)

New Jersey State Department of Health
WIC / HEALTHSTART

REFERRAL/NUTRITION ASSESSMENT FOR WOMEN

Please see instructions on reverse side.

NAME OF CLIENT	TELEPHONE NUMBER	DATE OF BIRTH
		___/___/___
ADDRESS OF CLIENT	CHECK ONE: ☐ Pregnant ☐ Breastfeeding ☐ Non-Breastfeeding	

REFERRAL *(To be completed by Health Professional, including reverse side.)*

ANTHROPOMETRIC AND LABORATORY DATE (One Blood Test is Required)

First Prenatal Check-up: Date: ___/___/___ # Weeks Gestation _____ Weight (Lbs.) _____ Pre-Preg. Wt. (Lbs.) _____ Usual Wt. (Lbs.) _____

Current Check-up: Date: ___/___/___ # Weeks Gestation _____ Weight (Lbs.) _____ Height (Inches) _____

Blood Test: Date: ___/___/___ Hb (mg/dl) _____ Hct _____ % EP (ug/dl) _____ Lead _____ Other _____

MEDICAL HISTORY

Gravida _____ Para _____ Ab/Misc _____ Stillbirth _____ EDC _____ ADC _____ ☐Vag ☐"C" Section

Past Med./Surg. History _____

Current Medical Problem(s) _____

Previous Preg. Complications _____ Date Last Preg. Ended ___/___/___

Physician/Clinic _____ Phone _____

Signature of Health Professional _____ Date ___/___/___

WIC APPOINTMENT: DATE: ___/___/___ TIME: _____

ASSESSMENT *(To be completed by Client or Health Professional.)*

1. Are you taking any of the following?
   - Vitamins/Minerals ☐ Yes ☐ No Amount: _____ Type: _____
   - Iron ☐ Yes ☐ No Amount: _____ Type: _____
   - Over-the-Counter Medicines ☐ Yes ☐ No Amount: _____ Type: _____
   - Special Medicines ☐ Yes ☐ No Amount: _____ Type: _____
   - "Street" Drugs ☐ Yes ☐ No Amount: _____ Type: _____
2. How much did you smoke before you were pregnant? Amount: _____
   How much do you smoke now? Amount: _____
3. How much beer, wine cooler, or liquor do you drink per week? Amount: _____
4. Are you on a special diet now? ☐ Yes ☐ No Prior to pregnancy? ☐ Yes ☐ No
5. Are you experiencing?

Nausea	☐ Yes	☐ No	Heartburn	☐ Yes	☐ No
Frequent Vomiting	☐ Yes	☐ No	Flatus ("Gas")	☐ Yes	☐ No
Diarrhea	☐ Yes	☐ No	Dental Problems	☐ Yes	☐ No
Constipation	☐ Yes	☐ No	Bleeding Gums	☐ Yes	☐ No

6. Do you eat?

Paint Chips	☐ Yes	☐ No	Dirt	☐ Yes	☐ No
Laundry Starch	☐ Yes	☐ No	Clay	☐ Yes	☐ No
Corn Starch	☐ Yes	☐ No	Plaster	☐ Yes	☐ No
Ice	☐ Yes	☐ No	Other Cravings	☐ Yes	☐ No

7. Do you have a working?

Stove	☐ Yes	☐ No	Sink with Water Supply	☐ Yes	☐ No
Refrigerator	☐ Yes	☐ No			

8. Are you on any program?

WIC	☐ Yes	☐ No	HealthStart/	☐ Yes	☐ No
Child Support Enf.	☐ Yes	☐ No	Presumptively Eligible	☐ Yes	☐ No
Food Stamps	☐ Yes	☐ No	AFDC/Medicaid	☐ Yes	☐ No

9. How do you plan to or presently feed your baby?
   Breastmilk ☐ Yes ☐ No Formula ☐ Yes ☐ No Undecided? ☐ Yes ☐ No
10. Do you do the following daily?
    - Work ☐ Yes ☐ No Type: _____
    - Care for Children ☐ Yes ☐ No How Many: _____
    - Exercise ☐ Yes ☐ No Type: _____
11. If pregnant, how much weight (pounds) do you plan to gain? _____
12. Where do you plan to or presently take your child for medical care?

_____

New Jersey State Department of Health
WIC / HEALTHSTART

REFERRAL/NUTRITION ASSESSMENT FOR WOMEN

INSTRUCTIONS

— AGENCY USE ONLY —

Referral Section ***(Complete by Health Professional.)***

1. Fill in client's name, address, phone number, date of birth, or use addressograph stamp.
2. Check status of woman being referred.
3. Fill in data on first prenatal check-up and current check-up, if applicable.
4. One blood test is required prior to submitting this form to WIC.
   Pregnant women need blood test which was done during pregnancy.
   Postpartum women (breastfeeding and non-breastfeeding) need blood test which was done after delivery.
5. Complete Gravida, Para, Abortions, Miscarriages.
6. Fill in EDC (Estimated Date of Confinement) for prenatal clients.
7. Fill in ADC (Actual Date of Confinement), vaginal or "C" Section delivery for postpartum clients.
8. Complete past medical/surgical history based on client's record.
9. Fill in any pertinent current medical problems diagnosed.

Information in this Section should Not Include most recent pregnancy for Postpartum Women.

10. Complete previous pregnancy complications, referring to list below:
    Write approximate letter or letters on space provided.
    a. Hx of low birth weight infant(s) (< 5.5 lbs.)
    b. Hx of premature infant(s) (< 37 weeks gestation)
    c. Hx of infant(s) > 10 lbs. at birth
    d. Hx of or planned C-section
    e. Multiple pregnancy or recent multiple birth.
    f. Medical problems (e.g., diabetes, hypertension, preeclampsia, eclampsia)
    g. Disability which may compromise adequacy of diet
    h. Social or environmental condition which may compromise adequacy of diet
    i. Substance use (e.g., alcohol, drugs, cigarettes, pica)
    j. Vitamin/mineral supplement or medicine prescription
    k. Special formula prescription and medical reason for its necessity
    l. Other pertinent health/medical data
11. Fill in physician's name or clinic and phone number.
12. Signature of referring health professional IS REQUIRED, with current date.

Assessment Section / Food Frequency ***(Page 1 and 2)***

1. This section may be completed by the client or a health professional.
2. If completed by client, it must be reviewed by the health professional for accuracy and completeness. Check the appropriate answer for questions 1-18. Any reponses which do NOT meet WIC and/or HealthStart standards demand further clarification.
3. The health professional should compare the food frequency with the recommended servings needed daily for pregnant/postpartum women and formulate a nutrition plan of care accordingly.
4. The Nutrition Assessment and Plan of Care must be written according to the hospital/ HealthStart Agency/WIC State policy and procedure.
5. Upon completion of nutrition education, the health professional must circle the appropriate Nutrition Education Topics and record the date. (More topics below.) If materials are provided, write the appropriate Topic Code in the space labelled "Other".

05 - Child Nutrition	11 - Mealtime Psychology	18 - Sugar in Diet
06 - Dental Health	12 - Nutrients in WIC Foods	19 - Vitamin A in Diet
07 - Fat in Diet	15 - Salt in Diet	20 - Vitamin C in Diet
08 - Food Budget/Consumer Awareness/Meal Planning	16 - Smoking & Pregnancy	44 - No Show
	17 - Snacking	45 - Client Refused
09 - Fruit and Vegetables		

NAME AND ADDRESS OF WIC PROGRAM, HEALTHSTART AGENCY, PHYSICIAN OR CLINIC:	TELEPHONE NUMBER

New Jersey State Department of Health
WIC / HEALTHSTART

REFERRAL/NUTRITION ASSESSMENT FOR WOMEN, Continued

NAME OF CLIENT	TELEPHONE NUMBER	DATE OF BIRTH
		___/___/___

CHECK ONE:

☐ Pregnant ☐ Breastfeeding ☐ Non-Breastfeeding

13. How is your appetite? ☐ Good ☐ Fair ☐ Poor
14. Do you have any allergies/intolerances? _____
15. Who does the food shopping? _____
16. Who cooks your food? _____
17. Where do you eat most of your meals? ☐ At home ☐ Restaurant/fast foods ☐ Other, specify: _____
18. Do you avoid any food due to cultural or religious practice? ☐ Yes ☐ No
    if yes, specify: _____

FOOD FREQUENCY *(How many times do you eat the following foods?)*

FOODS	DAILY	WKLY.	MTHLY.	NEVER
EXAMPLE: Milk (whole, 2%, 1% skim)	4			
Milk (whole, 2%, 1%, skim, other)				
Cheese				
Ice Cream, Yogurt, Pudding				
Meat, Poultry, or Fish (hamburger, roast beef, steak, pork chops, ribs, ham, chicken, turkey, fish, tunafish, lamb, liver, etc.)				
Luncheon Meats, Hot Dogs, Sausage, Bacon				
Eggs				
Dry Beans, Nuts, Peanut Butter				
Orange, Grapefruit (fruit or juice), Other WIC Juices				
Dark Green or Dark Yellow Fruits and Vegetables, Cantaloupe, Nectarine, Mango, Papaya, Spinach, Greens, Broccoli, Carrots, Plantain, Pumpkin (calabaza)				

FOODS	DAILY	WKLY.	MTHLY.	NEVER
Other Fruits and Vegetables (salad, peas, string beans, apples, pears, peaches, tomato, tomato sauce, .etc.)				
Cereal (hot or cold)				
Rice, Noodles, Macaroni, Corn, Potato				
Pizza, Soup, Spaghetti, Ravioli (in can or jar)				
Bread, Toast, Crackers, Rolls, Biscuits, Bagels, Tortillas, Pancakes, Waffles, Muffins				
Fruit Drinks (Kool-aid, Hi-C, Tang, Hawaiian Punch, etc.) Malta				
Soda, Coffee, Tea, Water				
Candy, Cake, Pie, Donut, Cookies, Pastry, Gelatin Desert				
Snacking Chips, Popcorn, Pretzels				
Fast Food (french fries, etc.)				

FOR STAFF USE ONLY*

Adult Women	Servings Needed Daily** Preg/ Brstfd	Non-Brstfd	Servings Consumed
Milk Product	3+	2-3	
Meat & Subst	6+ oz.	6 oz.	
Vege-tables	4+	4	
Fruits	3+	3	
Breads & Cereals	9+	9	

NUTRITION EDUCATION TOPIC CODES

Materials Provided	Date
01-Adolescent Prenatal Nutrition	
02-Anemia/Iron	
03-Breastfeeding	
04-Calcium	
10-Infant Nutrition	
13-Postpartum Nutrition	
14-Prenatal Nutrition	
21-Weight Control	
Other _____	

NUTRITION ASSESSMENT AND PLAN OF CARE:

RISK CODE: _____

WIC FOOD PKG. CODE: _____

1 2 3 4 5 6 7 8 9

SIGNATURE _____ DATE _____

HS-8
Revised 3/95

*SEE ATTACHMENT 208J OF NJ WIC POLICY & PROCEDURE MANUAL FOR TABLE OF STANDARD SERVING SIZES FOR WOMEN
**REFERENCE: USDA, "The Food Pyramid," 1992

#H4383

New Jersey State Department of Health
WIC / HEALTHSTART

REFERRAL/NUTRITION ASSESSMENT FOR WOMEN

INSTRUCTIONS

ASSESSMENT SECTION/FOOD FREQUENCY *(Page 1 and 2)*

1. This section may be completed by the client or a health professional.
2. If completed by the client, it must be reviewed by the health professional for accuracy and completeness. Check the appropriate answer for questions 1 - 18. Any responses which do NOT meet WIC and/or HealthStart standards demand further clarification.
3. The health professional should compare the food frequency with the recommended servings needed daily for pregnant/postpartum women and formulate a nutrition plan accordingly.
4. The Nutrition Assessment and Plan of Care must be written according to the hospital/HealthStart Agency/WIC State policy and procedure.
5. Upon completion of nutrition education, the health professional must circle the appropriate Nutrition Education Topic Code and write the date education was provided.
6. Listed below are a continuation of Nutrition Education Topics. If materials are provided, write the appropriate Topic Code in the space "Other."

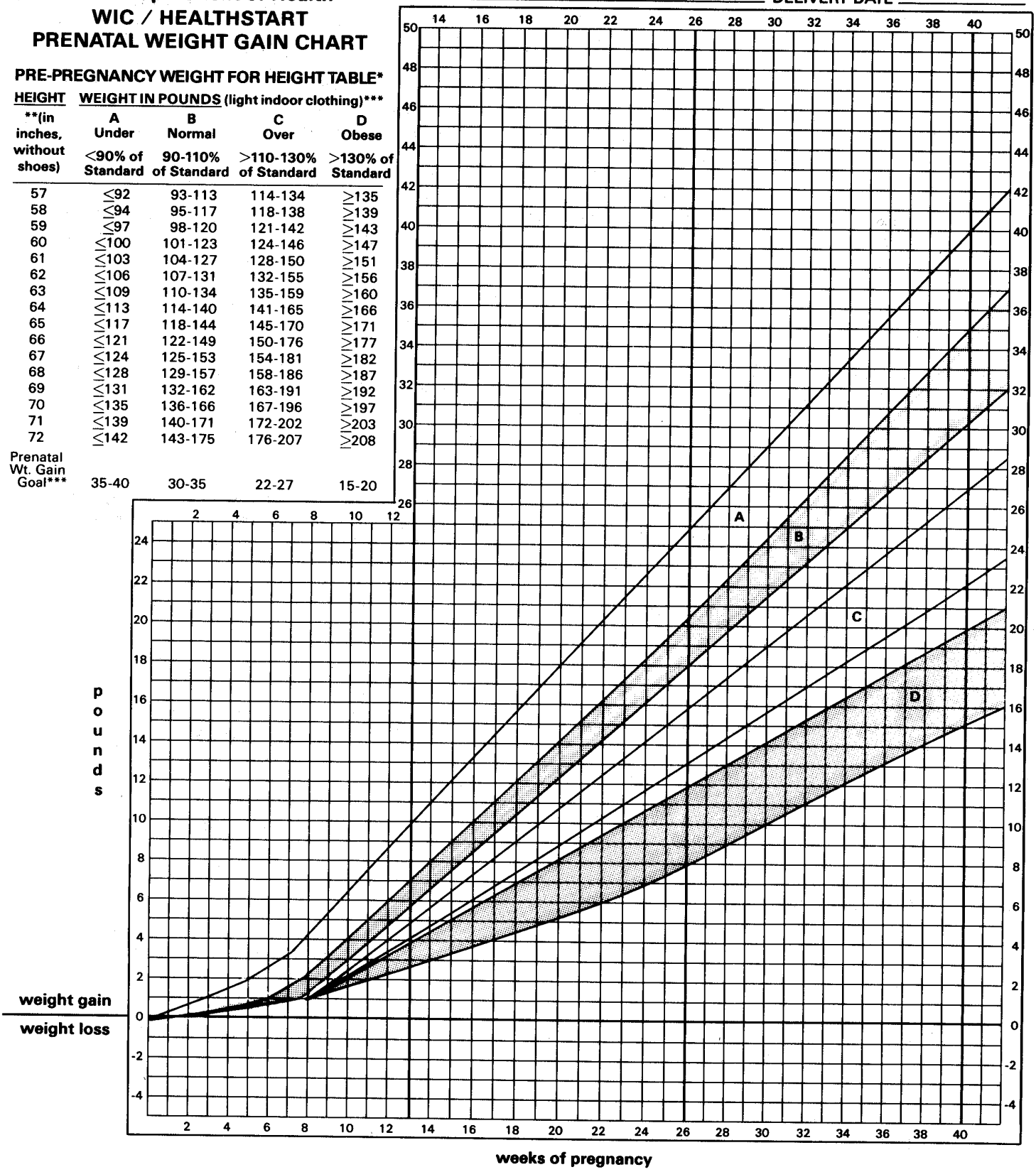
05 - Child Nutrition
06 - Dental Health
07 - Fat in the Diet
08 - Food Budgeting/Consumer Awareness/Meal Planning
09 - Fruit and Vegetables
11 - Mealtime Psychology
12 - Nutrients in WIC Foods
15 - Salt in the Diet
16 - Smoking and Pregnancy
17 - Snacking
18 - Sugar in Diet
19 - Vitamin A in Diet
20 - Vitamin C in Diet
44 - No Show
45 - Client Refused

New Jersey
State Department of Health
WIC / HEALTHSTART
PRENATAL WEIGHT GAIN CHART

NAME _____ ESTIMATED DELIVERY DATE _____

PRE-PREGNANCY WEIGHT FOR HEIGHT TABLE*

HEIGHT **(in inches, without shoes)	WEIGHT IN POUNDS (light indoor clothing)*** A Under <90% of Standard	B Normal 90-110% of Standard	C Over >110-130% of Standard	D Obese >130% of Standard
57	≤92	93-113	114-134	≥135
58	≤94	95-117	118-138	≥139
59	≤97	98-120	121-142	≥143
60	≤100	101-123	124-146	≥147
61	≤103	104-127	128-150	≥151
62	≤106	107-131	132-155	≥156
63	≤109	110-134	135-159	≥160
64	≤113	114-140	141-165	≥166
65	≤117	118-144	145-170	≥171
66	≤121	122-149	150-176	≥177
67	≤124	125-153	154-181	≥182
68	≤128	129-157	158-186	≥187
69	≤131	132-162	163-191	≥192
70	≤135	136-166	167-196	≥197
71	≤139	140-171	172-202	≥203
72	≤142	143-175	176-207	≥208
Prenatal Wt. Gain Goal***	35-40	30-35	22-27	15-20



* Add 3 pounds to the woman's weight if weighed without clothes.

** Height measurements of ≥ 1/2 inch should be rounded to the next whole inch.

*** For twin pregnancies: Normal weight women should gain 41 pounds; underweight women should gain 44 pounds.

Chart adapted with permission from the New York WIC Program.
Grid adaped from Judith Brown, Healthy Infant Outcome Project, University of Minnesota.

HS-17
Revised 4/96

— Please see reverse for instructions on completing this chart. —

#H4455

New Jersey Department of Health and Senior Services
WIC / HEALTHSTART

PRENATAL WEIGHT GAIN CHART

INSTRUCTIONS

1. Ascertain the pre-pregnancy weight of the pregnant woman by use of the Referral Form or by asking the woman to recall her weight prior to pregnancy. If possible, weigh and measure the pregnant woman. If not possible, use recent weight and height given on the Referral Form.

2. Circle both height and pre-pregnancy weight range of the pregnant woman on the Pre-pregnancy Weight for Height Table. If underweight range is circled, then Nutritional Risk Factor "07" can be used at certification. If overweight or obese range is circled, then Nutritional Risk Factor"08" can be used at certification. (See explanation of these codes in the table below.)

3. Subtract the pre-pregnancy weight from the weight at the most recent measurement. This is the weight change. A positive number indicates a gain in weight; a negative number indicates a loss of weight.

4. Calculate the number of weeks of pregnancy at the time of the weight measurement by using a gestational wheel or calculate it by using the Months to Weeks Conversion Table below.

5. Put an "X" on the chart in the location where the number of weeks of pregnancy intersects with the weight change calculated in instruction #4 above.

6. A woman at normal weight prior to pregnancy should gain 30-35 pounds (shaded area B on grid) during pregnancy. Women who are underweight, overweight, or obese prior to pregnancy should be assessed on an individual basis. Recommendations of the healthcare provider should be used, when available. It is recommended that an underweight woman gain 35-40 pounds (area A on grid), an overweight woman gain 22-27 pounds (area C on grid), and an obese woman gain 15-20 pounds (shaded area D on grid) during the entire pregnancy. Nutritional Risk Factors 04, 05, and 06 may be used at the discretion of the Competent Professional Authority (See explanation of these codes in the table below).

Nutritional Risk Factors for Women

04 Insufficient prenatal weight gain (as evidenced by weight gain chart or any weight loss or gain ≤2 lbs./month during 2nd or 3rd trimester or ≤2 lbs. during 1st trimester).

05 Irregular pattern of prenatal weight gain and loss (as evidence by weight gain chart).

06 Excessive prenatal weight gain pattern for body size (as evidence by weight gain chart or >2 lbs./week).

07 Low pre-pregnancy or postpartum weight (weight for height <90% of standard).

08 Obese or overweight pre-pregnant/postpartum women (obese = wt/ht > 120% of standard) (overweight = wt/ht > 110% of standard).

Months to Weeks Conversion Table

(Calculate from first day of last menstrual period)

1 month	=	4 weeks
2 months	=	9 weeks
3 months	=	13 weeks
4 months	=	18 weeks
5 months	=	22 weeks
6 months	=	27 weeks
7 months	=	31 weeks
8 months	=	36 weeks
9 months	=	40 weeks

New Jersey Department of Health and Senior Services
HealthStart
PO Box 364
Trenton, NJ 08625-0364

APPENDIX 17

Please Return By

COMPREHENSIVE MATERNITY CARE PROVIDERS
RECERTIFICATION SURVEY

Name of Agency	Date Certificate Expires / /	Medicaid Provider Number
Name of President/CEO	Telephone Number ( )	Medicaid Health Support Svcs. No. (Hosp-Based Only)

SECTION I – PRENATAL AND POSTPARTUM SERVICES

1. Prenatal Services Schedule (indicate hours):
   Monday _____ Thursday _____
   Tuesday _____ Friday _____
   Wednesday _____ Saturday _____
2. Prenatal Services Telephone Number: ( ) _____ - _____
3. Total Obstetrical Care Provider Hours and Days Available During Scheduled Sessions:
   Hours: _____ Days: _____
4. Do All Professionals Meet Minimum HealthStart Staffing Qualifications? ☐ Yes ☐ No
5. Are All Professionals New Jersey State Licensed? ☐ Yes ☐ No
6. Average Number of Enrollees:
   a. Scheduled Each Session: _____
   b. Seen Each Session: _____
   c. New Enrolled Each Month: _____
7. Current Number of:
   a. Prenatal Enrollees: _____
   b. Postpartum Enrollees: _____
8. Percentage of enrollees who "drop out of care:" _____ %
9. Percentage of enrollees who return for medical postpartum care: _____ %
10. Future Family Planning Provided By: ☐ Your Agency ☐ Referral
11. If by Referral, name of agency(ies) receiving referral:
    _____
12. At your agency, does the number of weeks between enrollee's first request for prenatal services and provision of the initial medical services ever exceed two (2) weeks? ☐ Yes ☐ No
    a. If Yes, explain why: _____
    _____

SECTION II – POLICY QUESTIONS

1. Is there an integrated plan of care for each enrollee that is reviewed and updated appropriately and includes ALL HealthStart components (Medical, Social/Psychological, Nutrition, Health Education)? ☐ Yes ☐ No (Explain)*
2. Is there a twenty-four (24) hour access procedure for enrollees? ☐ Yes ☐ No (Explain)*
3. Is there sufficient and appropriate documentation in the enrollees' charts for all comprehensive services provided (documentation means written, signed name, credentials, date)? ☐ Yes ☐ No (Explain)*

*Explain any "No" answers in the Comments Section.

COMPREHENSIVE MATERNITY CARE PROVIDERS
RECERTIFICATION SURVEY
(Continued)

SECTION II – POLICY QUESTIONS, CONTINUED

4. Is there a quality assessment/improvement program for the prenatal services? ☐Yes ☐No (Explain)*
5. Is there a signed agreement between your agency and WIC (for referrals using HS-8 form)? ☐Yes ☐No (Explain)*
6. Are there procedures in place for conducting uniform risk assessments, informed consent and confidentiality of records and care? ☐Yes ☐No (Explain)*

*Explain any "No" answers in the Comments Section.

SECTION III – SERVICES QUESTIONS

1. Are home visits provided/arranged:
   a. For high risk enrollees? ☐Yes ☐No (Explain)*
   b. For preventive health care enrollees? ☐Yes ☐No (Explain)*
   c. If Yes, by whom?
      ☐Your agency ☐Another agency name: _____
   d. If not provided, please explain:
      _____
2. Does your agency have any outreach program that facilitates early entry into prenatal care? ☐Yes ☐No (Explain)*
3. Is WIC on site when maternity care services are being provided ☐Yes ☐No (Explain)*
4. Is there an outstation Medicaid worker on site during maternity care services? ☐Yes ☐No
5. Is there EPSDT or HealthStart preventive pediatric care services provided by your agency? ☐Yes ☐No (Explain)*
6. Is your agency an authorized Presumptive Eligibility (PE) provider? ☐Yes ☐No
   a. If yes, name of PE contact person(s):
      _____
7. Is your agency a participating Managed Health Care provider for prenatal services? ☐Yes ☐No
   a. If yes, name(s) of the health maintenance organization (HMO):
      _____
      _____

*Explain any "No" answers in the Comments Section.

Comments regarding any aspect of HealthStart:

Completed By	Title
Signature of Unit Administrator	Date

Complete Page 3 of this Recertification Survey which is a staff roster for all obstetrical medical care and health support services staff who will provide HealthStart comprehensive maternity care services.

New Jersey Department of Health and Senior Services
HealthStart

APPENDIX 17

COMPREHENSIVE MATERNITY CARE PROVIDERS RECERTIFICATION SURVEY - STAFF ROSTER

Position	Staff/ Consult (S/C)	Name / Credentials License / Exp. Date	Hours Per Week	Hourly Breakdown					
				Medi-cal	Case Coord.	Health Educ.	Psych. Soc.	Nutr.	Other
TOTAL									

Staff or Consultant:
S = Salaried employee, paid fringe benefits, on staff
C = Paid hourly, or contract rate, not an employee, consultant

New Jersey Department of Health and Senior Services
HealthStart Program
PO Box 364
Trenton, NJ 08625-0364

APPENDIX 17

COMPREHENSIVE MATERNITY CARE CHART AUDIT

Name of Agency	Date

Patient Record Number	Birthdate / Age

Prenatal Visits This Audit

1st _____ Gestational Age (Weeks of Pregnancy) _____ EDC _____ Last _____ Total Visits _____

Code: C = Complete I - Incomplete A – Absent

C	I	A	ACCESS TO CARE
☐	☐	☐	Initial appointment within 2 weeks of request for services.
☐	☐	☐	Presumptive eligibility processing forms (FD 334 and Pregnancy Test)
☐	☐	☐	Identification of Case Coordinator
			ASSESSMENT TOOL FOR:
☐	☐	☐	Medical Risk Factors (MD)
☐	☐	☐	Nutritional (HS-8 form)
☐	☐	☐	Social-Psychological
☐	☐	☐	Health Education
			PLAN OF CARE TOOL
☐	☐	☐	Developed: Initial
☐	☐	☐	Review Update: Ongoing
			Case Conference/Consultation:
☐	☐	☐	Initial
☐	☐	☐	Ongoing
			MATERNITY MEDICAL CARE SERVICES
☐	☐	☐	Initial Prenatal Visit Content
☐	☐	☐	Risk Assessment (MD), Updates
☐	☐	☐	Subsequent Prenatal Visits
☐	☐	☐	Laboratory Results Signed by MD
☐	☐	☐	Transfer of Prenatal Records at 34th Week
☐	☐	☐	Intrapartum Services Provisions Made
☐	☐	☐	Postpartum Visit Content

C	I	A	HEALTH SUPPORT SERVICES PROVIDED
			Case Coordination Activities:
☐	☐	☐	Prenatal
☐	☐	☐	Postpartum
			Nutrition:
☐	☐	☐	Basic
☐	☐	☐	Subsequent
☐	☐	☐	Specialized (as needed)
☐	☐	☐	Extensive (Medical Referral)
☐	☐	☐	Postpartum (Referral Linkage)
			Social/Psychological:
☐	☐	☐	Basic
☐	☐	☐	Subsequent
☐	☐	☐	Specialized (as needed)
☐	☐	☐	Extensive (Medical Referral)
☐	☐	☐	Postpartum (Referral/Linkage)
			Health Education:
☐	☐	☐	Instructions
☐	☐	☐	Services (Childbirth Class, Breastfeed, Parenting, etc.)
☐	☐	☐	Postpartum (Reinforcement, etc.)
☐	☐	☐	**Preventive Home Visit Assessment:** Prenatal and/or Postpartum
☐	☐	☐	**High Risk Home Visit Assessment:** Prenatal and/or Postpartum
☐	☐	☐	**Preventive Health Support Service:** Postpartum Contact (Refer/Link/Close) Before 6 Week Med. Visit
☐	☐	☐	Utilization of Existing Community Resources

Comments:

Name of DHSS Consultant	Signature	Date

Name of Agency Staff Person	Signature	Date

REIMBURSEMENT RATES* (AS OF 4/1/89) AND DESCRIPTION OF SERVICES (PACKAGE)
FOR
MATERNITY HEALTH SUPPORT SERVICES (PACKAGE)

DESCRIPTION	RATE	CODE
! Enrollment Process* - Assistance with presumptive eligibility determination for Maternity Care recipients, when and if applicable - Patient registration and scheduling of the initial appointments - Counseling and referral for WIC, food stamps and other community-based services - Assignment of HealthStart cases coordinator - Outreach and follow-up on missed appointments	$30.00	W9040 (Note - This code may be billed only once during pregnancy by the same provider.)
! Development of Maternity Plan of Care* - Case coordination services - Initial assessments 1. nutrition 2. health education 3. social/psychological - Case conference with Maternity Medical care provider - Initial plan of care developed by the HealthStart case coordinator - Basic guidance and health education services - Referral for other needed services including follow-up with County Welfare Agency "/Board of Social Services" - Outreach, referral and follow-up activities including phone calls and letters	$120.00	W9041 (Note - This code may be billed only once during pregnancy by the same provider.)
! Subsequent Maternity Health Support Services - Case coordination - Review and update of care plan - Coordination with maternity medical care provider - Health education instruction - Social/psychological guidance - Nutrition guidance - Home visit for high risk clients - Outreach, referral and follow-up activities including phone calls and letters	$50.00	W9042 May be billed once during 2nd and once during 3rd trimester and <u>not more</u> than twice per pregnancy

***** New Jersey Register Monday February 1, 1988.

****** These services must be provided prior to request for reimbursement and there must be adequate and sufficient documentation in the patient record to support this Division of Medical Assistance and Health Services Adopted New Rules: N.J.A.C. 10:49-3.1-3:20.

REIMBURSEMENT RATES* (AS OF 4/1/89) AND DESCRIPTION OF SERVICES (PACKAGE)
FOR
MATERNITY HEALTH SUPPORT SERVICES (PACKAGE)

DESCRIPTION	RATE	CODE
! Postpartum Maternity Health Support Services - Case coordination services - Review of the plan of care - Review of the summary of hospital stay records and current medical status - Nutrition assessment and counseling - Social/psychological assessment and counseling - Health education assessment and instruction - Home visit(s) as applicable - Referral, outreach and follow-up services including phone call "(.)" "and" letters - Referral for pediatric preventive care and follow-up - Transfer of pertinent information to pediatric, future family planning and medical care providers - Completion of the plan of care	$100.00	W9043

***** New Jersey Register Monday February 1, 1988.

****** These services must be provided prior to request for reimbursement and there must be adequate and sufficient documentation in the patient record to support this Division of Medical Assistance and Health Services Adopted New Rules: N.J.A.C. 10:49-3.1-3:20.

NEW JERSEY REGISTER, MONDAY, FEBRUARY 1, 1988 CITE 20 N.J.R. 285				
HCPCS	**MAXIMUM FEE ALLOWANCE**			**CODE**
	Spec.	**N Spec.**	**WM (CNM)**	
! **HealthStart*** - Initial antepartum maternity medical visit	$72.00	$69.00		W9025
! **HealthStart***			$67.00	W9025WM
- Initial antepartum maternity medical care visit by certified nurse midwife - History, including system review - Complete physical examination - Risk assessment - Initial care plan - Patient counseling and treatment - Routine and special laboratory tests on site, or by referral, as appropriate - Referral for other medical consultations, as appropriate (including dental) - *Coordination with the@ HealthStart AHealth* Support Services provider, as applicable - Case conference with HealthStart case coordinator				
! **HealthStart*** - Subsequent antepartum maternity medical care visit	$22.00	$21.00		W9026
! **HealthStart***			$19.00	W9026W
- Subsequent antepartum maternity medical care visit by certified nurse midwife - Interim history - Physical examination - Risk assessment - Review of plan of care - Patient counseling and treatment - Laboratory services on site or by referral, as appropriate - Referrals for other medical consultations, as appropriate - *Coordination with HealthStart case coordinator*				(Note - This code may be billed only for the 2nd through 15th antepartum visit.) (Note - If medical necessary dictates, corroborated by the record, additional visits above the initial and fourteen subsequent visits may be reimbursed under procedure code 90040, 90050, 90060, and* 90070. (90050 WM, *90060 WM, 90150 WM, 90160 WM, *routine or follow-up visit, midwife.)
! **HealthStart Regular Delivery**	$465.00	$418.00		*W9027

NEW JERSEY REGISTER, MONDAY, FEBRUARY 1, 1988 CITE 20 N.J.R. 285				
HCPCS	**MAXIMUM FEE ALLOWANCE**			**CODE**
	Spec.	**N Spec.**	**WM (CNM)**	
! HealthStart Regular Delivery by Certified Nurse Midwife - Admission History - Complete physical examination - Vaginal de-+livery with or without episiotomy - Inpatient postpartum care - Referral to postpartum follow-up care provider including: 1. Mother-s hospital discharge summary 2. Infant-s discharge summary, as appropriate			$317.00	W9027WM (Note: Obstetrical delivery applies to a vaginal delivery at full term or premature and includes care in the home, birthing center or in the hospital (inpatient setting).)
! HealthStart Postpartum Care Visit	$22.00	$21.00		*W9028
! HealthStart Postpartum Care Visit by Certified Nurse Midwife - Outpatient postpartum care by the 60th day after the vaginal or Cesarean section delivery - Review of prenatal, labor and delivery course - Interim history, including information on feeding and care of newborn - Physical examination - Referral for laboratory services as appropriate - Referral for ongoing medical care when appropriate - Patient counseling and treatment			$19.00	(Note - The postpartum visit shall be made by the 60th postpartum day.)
! HealthStart* Regular Delivery and Post-partum	$487.00	$439.00		W9029
! HealthStart* Regular Delivery and Post-partum by Certified Nurse Midwife - Admission History - Complete physical examination - *Vaginal delivery with or without episiotomy - Inpatient postpartum care - Referral to postpartum follow-up care provider including: 1. Mother-s hospital discharge summary 2. Infant-s discharge summary, as appropriate			$390.00	*W9029WM (Note - *This code* applies to a vaginal delivery at full term or premature and includes care in the home, birthing center or in the hospital (inpatient setting). This shall also include one post hospital discharge visit by the 60th postpartum day.

NEW JERSEY REGISTER, MONDAY, FEBRUARY 1, 1988 CITE 20 N.J.R. 285				
HCPCS	**MAXIMUM FEE ALLOWANCE**			**CODE**
	Spec.	**N Spec.**	**WM (CNM)**	
- Outpatient postpartum care by the 60th day after the delivery - Review of prenatal, labor and delivery course - Interim history, including information on feeding and care of the newborn - Physical examination - Referral of laboratory services as appropriate - Referral for ongoing medical care when appropriate - Patient counseling and treatment				
! HealthStart Total Obstetrical Care	$867.00			*W9030*
			$802.00	*[W9028WM]*
! HealthStart Total Obstetrical Care by Certified Nurse Midwife			$723.00	*W9030WM*
- Total obstetrical care consists of: 1. Initial antepartum visit and fourteen subsequent antepartum visits. 2. Obstetrical delivery per vagina with or without episiotomy including care when provided in the home, birthing center or in the hospital (inpatient setting). This applies to a vaginal delivery at full tem or premature. This shall also include one post hospital discharge visit by the 60th postpartum day.				(Note - Reimbursement will be decreased by the fee for the maternity medical care initial antepartum visit if the patient is not seen for this visit. The total fee will also be decreased by the reimbursement sum for each subsequent maternity medical care antepartum visit less then fourteen visits.)
! HealthStart Cesarean Section Delivery	$595.00	$531.00		*W9031
- Admission History - Complete physical examination - Cesarean section delivery - Inpatient postpartum care - Referral to postpartum follow-up care provider including: 1. Mother=s hospital discharge summary 2. Infant=s discharge summary, as appropriate				